



MONTANA HIGH SCHOOL ASSOCIATION

PROMOTING SUCCESS ON THE COURT, ON THE FIELD, ON STAGE
AND EVERYWHERE ELSE UNDER THE BIG SKY SINCE 1921.

May 2023

**TO: PARENTS OF MHSA SPORTS PARTICIPANTS
LICENSED MEDICAL PROFESSIONALS**

FROM: BRIAN MICHELOTTI, EXECUTIVE DIRECTOR

RE: UPDATED MHSA PRE-PARTICIPATION PHYSICAL EXAM FORM

Article II, Section (3) of the MHSA Handbook requires that a physical exam must be performed for each student for that student to be considered eligible for participation in an Association Contest. Physical exams must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year.

Logan Health, the official health care provider of the MHSA, is a new sponsor of the MHSA Pre-Participation Physical Form. Parents/guardians may use the medial provider of their choice for the Pre-Participation Physical Examination for their student athlete.

The MHSA Executive Board approved important additions to this form. Specifically, questions concerning the cardiac history and cardiac health of the student were added (questions 6-15), and an updated section on vaccinations which needs to be complete. **This year, the two questions regarding COVID-19 have been removed.**

This MHSA pre-participation form is the only form that will be allowed for the student's exam (**no other forms will be accepted**). The following process should be followed:

- Parent(s)/legal guardian(s) and their student will fill out the questionnaire and history portion of the form together.
- A medical provider will review the form with the student and parent/guardian and perform the exam. A signature from the medical provider is required to clear the student for participation.
- The student and parent/guardian will sign the form.
- The completed MHSA pre-participation form physical exam will be given to the appropriate school administrator.

The MHSA is committed to the safety and health of our student activity participants and believes this new form will facilitate that objective.

If you have any questions regarding the updated pre-participation examination form, please contact me.



MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. While Logan Health is the preferred medical provider of the MHSA, parents/guardians may choose their own medial provider for their Physical Examination This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)
Name _____ Male [] Female [] Grade _____ Date of Birth _____
Home Address _____ Phone Number _____
Parent's Name _____ Family Physician _____
Current School _____ Date _____

Explain "Yes" answers below. Circle questions to which you don't know the answer.

- 1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have an ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
...
23. Do you regularly use a brace or assistive device?
24. Has a doctor ever told you that you have asthma or allergies?
...
48. Have you ever had a menstrual period?
49. How old were you when you had your first menstrual period?
50. How many periods have you had in the last year?

Allergies: _____
Required for School* and Recommended Immunizations: (please check if student is up-to-date): [] Hepatitis A; [] Hepatitis B; [] Human Papillomavirus (HPV); [] Influenza; [] Measles, Mumps, Rubella (MMR)*; [] Meningococcal; [] Polio*; [] Tetanus/Diphtheria/Pertussis (Tdap)*; [] Varicella (Chickenpox)*

Date of last known tetanus shot (Tdap): _____

PROVIDER'S PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP: Left Arm _____ / _____ Right Arm _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: _____

CLEARANCE

Typed or printed name of Student _____ Signature of Student _____

Cleared without restriction
 Cleared with recommendations for further evaluation or treatment for: _____

Not cleared for All sports Certain sports _____ Reason: _____
 Recommendations: _____

Name of physician/medical provider [print or type] _____ Date _____

Address _____ Phone _____

Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian _____

Signature of parent or guardian _____

Date _____

Address _____

Insurance (Company name) _____

Parent's Home Phone _____

Parent's Work Phone _____

Parent's Cell Phone _____

Additional Phone (if any-specify) _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Updated (4/23)